STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495156	A. BUILDING _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROANOKE	324 KING GEORGE AVE SW ROANOKE, VA 24016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid compliant investigation survey was conducted 8/13/19 through 8/21/19. One (1) complaint was investigated during the course of the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 130 certified bed facility was 79 at the time of the survey. The final survey sample consisted of nine (9) current resident reviews and one (1) closed record review.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		10/4/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/19/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to notify the physician of changes in assessments and/or the availability of medications for 4 of 10 residents in the survey sample (Resident #C1, #C2, #C5 and #C6). The findings included: 1. The facility staff failed to notify the physician of when medications were administrated to Resident # C1 an hour or later after the medications had	F 580	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Physician was notified of medications given an hour or later after the medications had been scheduled on the MAR for resident #C1 on 8/15/19 by director of nursing with no new orders given. Physician was notified of medications given an hour or later after the medication	

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F 580	Continued From page 2 been scheduled on the MAR (Medication Administration Record). Resident #C1 was admitted to the facility on 10/16/18 with the following diagnoses of, but not limited to neurogenic bladder, quadriplegia, depression and respiratory failure. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/22/19, coded the resident as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing. Resident #C1 was also coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. On 8/14/19 at 2:30 pm, the resident asked to speak to the surveyors that were in the building. The facility staff pushed Resident #C1's chair into the conference room. Surveyor #1 and #2 attended also. The resident stated, "I don't get my medicine on time. It's never being given to me when it is supposed to be given. Surveyor #2 stated to the resident that this concern would be reviewed and see why the medications are not given on time. At 3 pm, Surveyor #1 requested copies of the time analysis for Resident #C1 for the dates of 7/1/19 through 8/15/19 concerning administration of medications. The administrator and DON (director of nursing) stated they would obtain copies of this report and give to the surveyor. At 4:30 pm, the administrator brought the requested copies to the surveyor. In the time analysis report of the resident's MAR (medication administration record) the dates of 7/1/19 through 8/15/19, the surveyor noted the following	F 580	was scheduled to be given for resident #C2 on 8/15/19 by director of nursing with no new orders given. Wound Physician was notified of foul odor and excessive drainage from pressure ulcers for resident #C5 on 8/19/19 by director of nursing with no new orders given. Physician was notified that resident #C6 had missed six doses of IV antibiotic on 8/19/19 by director of nursing with no new orders given. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of the MAR will be completed by 9/19/2019 by Director of Nursing to identify any “missed medications”, to include IV antibiotics, as well as a time analysis to identify concerns and or needed follow up. An audit of residents with pressure injury was conducted by unit coordinator and wound physician on 09/17/2019. No new findings were noted. Monitoring process and systemic changes to ensure plan of correction is effective: The licensed nursing staff were educated on 8/27/19 by Administrator and Director of Nursing regarding notification of physician for availability of medications, medications given an hour or later after the medication was scheduled to be given, timely IV antibiotics administration, and the presence of foul odors and/or excessive drainage from pressure ulcers. Weekly audits will be conducted by	

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F 580	Continued From page 3 documentation: a) " ...Glycopyrrolate 1 mg (milligram) Give 2 tablet by mouth three times a day for secretions. The medication was schedule for 09:00, 1400 (2 pm) and 2100 (9 pm) ..." The facility staff documented that this medication had been given to Resident #C1 1-4 hours after the time that this medication was scheduled to be given. b) Trazodone 100 mg Give 1 tablet by mouth one time a day for depression. Take a bedtime. The medication was scheduled to be given at 2100 (9 pm). On 7/1/19, it was given at 02:03 (2:03 am), 7/5/19 it was given at 2244 (10:44 pm), 7/6/19 it was given at 2226 (10:26 pm), 7/7/19 it was given at 0410 (4:10 am) on 7/8/19, 7/9/19 was given at 0257 (2:57 am) on 7/10/19, 7/11/19 it was given at 0120 (1:20 am) on 7/12/19, 7/12/19 was given at 2223 (10:23 pm), 7/14/19 was given at 2236 (10:36 pm), 7/19/19 was given at 2311 (11:11 pm), 7/20/19 was given at 0122 (1:22 am) on 7/21/19, 7/22/19 was given at 2317 (11:17 pm), 7/23/19 was given at 2320 (11:20 pm), 7/24/19 was given at 0037 (12:37 am) on 7/25/19, 7/25/19 was given at 0022 (12:32 am), 7/26/19 was given at 2231 (10:31 pm), 7/21/19 was given at 0030 (12:30 am) on 7/22/19, 7/27/19 was given at 2253 (10:53 pm), 7/28/19 was given at 2224 (10:24 pm), 8/3/19 was given at 2305 (11:05 pm), 8/5/19 was given at 2353 (11:53 pm), 8/6/19 was given at 0106 (1:06 am) on 8/7/19, 8/10/19 was given at 2350 (11:50 pm) and 8/14/19 was given at 2235 (11:35 pm). The surveyor reviewed the nurses' notes for the above documented dates and times. There was no documentation to state why the resident was receiving medications other than how they had	F 580	Director of Nursing to review current resident's medication administration times as well as observation of residents with pressure injury for 4 weeks then monthly for 2 months. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: Effective 9/18/19 the Director of Nursing will report the findings of audits to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Include dates when corrective action will be completed: October 4th, 2019 Title of person responsible for implementing the acceptable plan of correction: Director of Nursing or designee	

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been scheduled.

On 8/16/19 at 10 am, the DON (director of nursing) and the administrator were notified of the above documented findings. The DON stated, "I was not aware of this going on with this resident until you requested copies of this report. I would expect the nurses to notify the physician of why the medications were not being administrated on time and I would expect the staff to come and brain storm together to see if other times were acceptable to give these medications."

No further information was provided to the surveyor prior to the exit conference on 8/21/19.

2. The facility staff failed to notify the physician of when medications were being administrated to Resident #C2 an hour or later after the medication was scheduled to be given.

Resident #C2 was admitted to the facility on 3/27/17 with the following diagnoses of, but not limited to high blood pressure, pneumonia, diabetes, stroke, quadriplegia, depression and respiratory failure. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) 6/5/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #C2 was also coded as being totally dependent on 1-2 staff members for dressing, personal hygiene and bathing.

On 8/14/19 at 1 pm, Resident #C2 asked to speak to the surveyors that were in the building. The resident was able to come to the conference room using his motorized wheelchair. Resident #C2 stated to the survey team that he never got

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his medicine on time like he was supposed to. The survey team verbalized to the resident that the medications would be reviewed. The resident verbalized understanding.

On 8/20/19 at 9 am, the surveyor reviewed the clinical record including the MAR (medication administration record) for 8/1/19 through 8/20/19. The surveyor requested copies of the time analysis report for the above dates for this resident.
The administrator brought copies of the requested report to the surveyor. During this review, the following was noted in the documentation:

a) Baclofen 10 mg (milligram) Give 1.5 tablet by mouth three times a day. This medication was scheduled to be given to the resident at 12 am, 8 am and 4 pm. On 8/1/19, the medication was given at 14:13 (2:13 pm). On 8/3/19, it was given at 14:14 (2:14 pm), 8/4/19 was given at 15:33 (3:33 pm), 8/5/19 was given at 12:44 (12:44 pm), 8/6/19 was given at 18:35 (6:35 pm), 8/9/19 was given at 09:25 (9:25 am), 8/10/19 was given at 09:57 (9:57 am), 8/11/19 was given at 10:56 (10:56 am), 8/13/19 was given at 11:15 (11:15 am), 8/16/19 was given at 12:24 (12:24 pm) and8/18/19 was given at 09:58 (9:58 am).

b) Morphine 0.125 ml (milliliter) by mouth four times a day. On 8/1/19 it was scheduled to be given at 12:00 but was documented as being given at 14:13 (2:13 pm). 8/3/19 dose was scheduled to be given at 18:00 (6 pm) but was documented as being given on 8/4/19 at 07:52 (7:52 am). 8/4/19 was scheduled to be given at 12:00 but it was documented as being given at 15:53 (3:53 pm). 8/6/19 was scheduled to be

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given at 12:00 but it was documented as being given at 14:12 (2:12 pm). 8/7/19 was scheduled for 12:00 but it was documented being given at 16:08 (4:08 pm). 8/8/19 was scheduled to be given at 12:00 but it was documented as being given at 15:45 (3:45 pm).

The surveyor reviewed the nurses notes for the above documented dates and times and there was no documentation of the physician being notified when the medications were given to the resident on times other than as scheduled.

On 8/16/19 at 10 am, the DON (director of nursing) and the administrator were notified of the above documented findings. The DON stated, "I was not aware of this going on with this resident until you requested copies of this report. I would expect the nurses to notify the physician of why the medications were not being administrated on time."

No further information was provided to the surveyor prior to the exit conference on 8/21/19.
3. The facility staff failed to notify the physician of foul odor and excessive drainage from pressure ulcers for Resident # C5.

Resident #C5 was a 51-year-old-male who was admitted to the facility on 5/17/17, with a readmission date of 5/21/19. Diagnoses included but were not limited to, stage 4 pressure ulcer, quadriplegia, type 2 diabetes mellitus, and major depressive disorder.

The clinical record for Resident #C5 was reviewed on 8/19/19 at 2:50 pm. The most recent MDS (minimum data set) assessment for Resident # C5 was a significant change

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assessment with an ARD (assessment reference date) of 5/24/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # C5 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # C5 was cognitively intact. Section M of the MDS assesses skin conditions. In Section M0210, the facility staff documented that Resident # C5 had 1 or more pressure ulcers/injuries.

The current plan of care for Resident #C5 was reviewed and revised on 5/9/19. The facility staff documented a focus area for Resident # C5 as, "Resident # C5 has PU (pressure ulcers), long standing/with history of osteomyelitis, and bone deterioration/hx (history) of MRSA (methicillin-resistant staphylococcus aureus) in wound due to quadriplegia. He is at risk for further PU development due to immobility. He has a specific position that he prefers while in bed and refuses to be turned and positioned. He utilizes chemotherapeutic agents for recurrent leukemia." Interventions included but were not limited to, "Assess/record/observe wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and decline to MD (medical doctor)."

Resident # C5 had orders that included but were not limited to, "Dakin's (1/4 strength) Solution 0.125% Apply to sacral topically every day shift for wound clean w/ns (with normal saline) apply Dakin moist gauze & cover w (with)/border gauze daily till resolved," which was initiated by the physician on 5/21/19.

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On 8/19/19 at 2:15 pm, the surveyor was in Resident # C5's room conducting a Resident interview. The surveyor asked Resident # C5 if the nurse's had been changing his pressure ulcer wounds every day. Resident # C5 stated, "It didn't get changed yesterday." The surveyor asked Resident # C5 for permission to observe his wounds. Resident # C5 agreed to allow surveyor to observe his wounds.

On 8/19/19 at 2:25 pm, the surveyor, RT #1 (respiratory therapist) and CNA # 1(certified nursing assistant) entered Resident # C5's room to observe his wounds. Resident # C5 was turned to his right side with the assistance of RT # 1 and Cna #1. Once turned, the surveyor observed an undated dressing on Resident # C5's left hip, and dressings in place on Resident # C5's right and left buttock that had peeled off and partially covered the wound. The surveyor observed that both dressings were undated. The surveyor RT # 1 and CNA # 1 smelled a profound foul odor coming from Resident # C5's wounds, and observed a folded sheet underneath of Resident # C5 that was completely saturated with green, yellow, and brown drainage.

On 8/20/19 at 10:00 am, the surveyor reviewed the August 2019 TAR (treatment administration record) for Resident # C5. The surveyor observed that the facility staff documented that treatment was provided to Resident # C5's sacral pressure ulcer on 8/19/19. The surveyor reviewed the progress notes for Resident # C5. The surveyor did not locate any documentation of an assessment of the drainage and odor from Resident # C5's wound.

On 8/20/19 at 10:15 am, the surveyor made the

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administrator and director of nursing aware of the drainage and odor for Resident # C5's wound. The director of nursing stated that the wound doctor was in the building and would have Resident # C5's pressure ulcers assessed.

On 8/20/19 at 3:00 pm, the director of nursing informed the surveyor that she had gone into Resident # C5's room with the wound doctor to assess the wound. The director of nursing agreed that Resident # C5's sacral pressure ulcer had a foul odor and drainage, and that there was no documentation or notification made to the physician regarding the foul odor and drainage noted to Resident # C5's sacral pressure ulcer.

The facility policy for "Change in a Resident's Condition or Status" contained documentation that included but was not limited to, ..."The nurse will notify the resident's attending physician or physician on call when there has been a(an): d. significant change in the resident's physical/emotional/mental condition." ...

On 8/20/19 at 4:06 pm, the administrator and director of nursing were made aware of the findings as stated above and given the opportunity to provide additional information.

No further information regarding this issue was provided to the survey team prior to the exit conference on 8/21/19.

4. The facility staff failed to notify the physician that Resident # C 6 had missed six doses of IV (intravenous) antibiotic that had been prescribed for sputum infection.

Resident # C6 was a 65-year-old-male who was

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originally admitted to the facility on 1/16/19, with a readmission date of 7/26/19. Diagnoses included but were not limited to. BPH (benign prostatic hyperplasia), anxiety, heart failure, and hypertension.

The clinical record for Resident # C6 was reviewed on 8/19/19 at 2:45 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/30/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # C6 had a BIMS score (brief interview for mental status) of 14 out of 15, which indicated that Resident # C6 was cognitively intact. Section H of the MDS assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # C6 had an indwelling catheter.

The current plan of care for Resident # C6 was reviewed and revised on 4/10/19. The facility staff documented a focus area for Resident # C6 as, "Resident # C6 requires ventilator support." Interventions included but were not limited to, "Administer medications as ordered."

On 8/20/19 at 11:00 am, the surveyor reviewed the current orders for Resident # C6. The surveyor observed that Resident # C6 had an order that had been initiated by the physician on 7/28/19 for "Cefepime HCl Solution 2 gm (grams)/100ml (milliliters) Use 2 gram intravenously every 8 hours for sputum infection until 8/3/19." The surveyor reviewed the July and August 2019 medication administration records for Resident # C6 and observed documentation that Resident # C6 did not receive Cefepime as ordered by the physician on the following dates

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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and times:
7/28/19 at 8:00 am
7/30/19 at 8:00 am
7/30/19 at 4:00 pm
7/30/19 at 12:00 midnight
7/31/19 at 12:00 midnight
8/2/19 at 4:00pm

The surveyor reviewed the entire clinical record for Resident # C6 and did not locate any follow up with the physician to notify that Resident # C6 had missed six doses of IV Cefepime that had been ordered to treat a sputum infection for Resident # C6. The surveyor also did not observe any follow up labs to determine if Resident # C6's sputum infection had resolved since the entire course of antibiotics had not been delivered per physician's orders.

The facility policy on "Change in a Resident's Condition or Status" contained documentation that included but was not limited to, ..."The nurse will notify the resident's attending physician or physician on call when there has been a (an): e. need to alter the resident's medical treatment significantly." ...

On 8/20/19 at 4:06 pm, the administrator and director of nursing were made aware of the findings as stated above and provided the opportunity to submit additional information to the survey team.

On 8/21/19 at 9:54 am, the director of nursing informed the surveyor that no documentation of physician notification that Resident # C6 had missed 6 doses of IV Cefepime for the treatment of a sputum infection.

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F 580	Continued From page 12 No further information regarding this issue was presented to the survey team prior to the exit conference on 8/21/19.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file	F 585		10/4/19

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grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance,

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F 585	Continued From page 14 the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, it was determined the facility staff failed to ensure grievances were resolved according to the facility's policy and procedure for one (1) of ten (10) residents (Resident #C7). The findings included: The facility staff failed to have documented evidence of addressing grievances reported by Resident #C7's family member. During an interview on 8/15/19 with Resident #C7's sibling, the sibling reported he/she had submitted two (2) grievances and had not received a response. Review of the facility's Grievance Log did not include the two grievances that Resident #C7's sibling reported he/she had	F 585	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Administrator met with family of resident #C7 to review concerns from grievances submitted on 7/18/19 and 8/8/19. A new grievance form was completed with concerns on 8/21/19, and family expressed satisfaction and confirmed that concerns had been resolved. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A 100% audit by social worker of alert and oriented residents was completed on 9/17/19 to identify any unresolved	

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F 585	Continued From page 15 submitted. On 8/14/19 at 3:30 p.m., the facility's Director of Nursing (DON) provided the survey team with a facility document with the title of "Grievance Policy". This policy included the following information: - "Grievance from any non-resident will receive a verbal, and if requested, written response within 5 (five) working days or will be notified if the investigation requires more time." - "Upon receiving a grievance report the GC (Grievance Coordinator) will log the grievance on the Grievance Tracking Log and place the original grievance in the Grievance Binder." - "The GC is accountable for managing the grievance process from submission of the grievance through to its' [sic] conclusion, including a written response to the resident and/or responsible party." Resident #C7's sibling was interviewed on 8/20/19 at approximately 10:00 a.m. The resident's sibling reported he/she had submitted two grievances. He/She reported the first grievance was slid under the Director of Nursing's (DON's) door. (The first grievance was on 7/18/19; the facility's current DON was not the DON at that time.) Resident #C7's sibling reported he/she had handed the second grievance to Staff Member (SM) #11 on 8/8/19. On 8/20/19 at 10:14 a.m., SM #11 was interviewed about receiving the aforementioned grievance. SM #11 confirmed he/she did receive the grievance from Resident #C7's family member and that he/she handed the grievance to the facility's Administrator. On 8/20/19 at 4:00 p.m., during a survey team	F 585	grievances. Alert and oriented was defined as having a BIMS of 8 or higher as per the last assessment in the medical record. New grievances will be reviewed daily, Monday through Friday, during morning meeting by social worker and Administrator Address what measures will be put into place or systemic changes made to ensure the deficient practice will not recur: Administrator was re-educated on grievance policy by Regional Director of Operations on 9/17/19. All department heads were re-educated on grievance policy by the Administrator on 9/18/19. All current staff, to include nurses, CNAs, housekeeping, laundry, and dietary were educated on the grievance policy on 9/18/19. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 9/18/19 the Administrator will report the findings of the audits to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Dates when corrective action will be completed: October 4th, 2019 Title of person responsible for	

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F 585	Continued From page 16 meeting with the facility's Administrator and Director of Nursing, the failure of facility staff to ensure Resident #C7's family member's grievances were addressed, using the facility's grievance process, was discussed.	F 585	implementing acceptable plan of correction: Administrator	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility failed to prevent further potential abuse, neglect, exploitation, or mistreatment by assessing and ensuring interventions were in place for 1 of 10 residents involving resident-to-resident verbal, mental or physical abuse (Resident C#3). The findings included:	F 610	Address how corrective action will be accomplished for those residents found to have been affected by deficient practice: Resident #C3's care plan was updated by Director of Nursing on 8/14/19 to reflect the incident with previous roommate. Administrator met with resident #C3 on 8/14/19. Resident #C3 stated to administrator that he had not received any further messages from his previous	10/4/19

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F 610	Continued From page 17 The facility staff failed to assess and ensure interventions were in place for Resident C#3 concerning the resident's well-being while in the facility. Resident C#3 was readmitted to the facility 7/29/19 with the following diagnoses of, but not limited to anemia, orthostatic hypotension, neurogenic bladder, septicemia, anxiety disorder, manic depression and quadriplegia. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/2/19, the resident had a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident C#3 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing. On 8/14/19, the resident asked to speak to a surveyor. At approximately 10 am, Surveyor #1 and Surveyor #2 went into the resident's room to speak to the resident. Resident C#3 informed the 2 surveyors that while he (Resident C#3) was in the hospital this last time, the roommate or his family got 4 pairs of shirts and 2 pairs of pants. The staff was asked to look for these and the aides stated they couldn't find them. He was this resident's roommate until the resident came back from the hospital and C#3 was having problems with someone buying pizza and having it delivered here (facility) on his debit card. Resident C#3 also stated that he had been receiving multiple texts or chat room discussions where they were talking about him. Resident C#3's roommate was moved to a new room at the end of the hallway. #C3 stated that he still has the staff to push his chair to the second room on the left and leave him sitting there. C3 stated	F 610	roommate, and that he and his previous roommate had spoken the evening before and things were okay. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All charts of residents involved in resident to resident altercations within the last 90 days were reviewed by IDT team on 9/18/19, and care plans updated to address interventions and any need for change. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Licensed staff were re-educated on abuse, neglect, exploitation, and mistreatment, to include resident to resident altercations, and care plan updates by Administrator and DON on 8/27/19. Each resident to resident altercation will be reviewed after each incident by the IDT and interventions put into place on the care plan. Weekly audits will be conducted by Director of Nursing to review residents involved in resident to resident altercations to ensure care plans are updated and interventions are put into place. This will occur weekly for 4 weeks and monthly for 2 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:	

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F 610	Continued From page 18 that the former roommate talks real loud so that #C3 hears what he is saying. Surveyor #2 asked if he felt afraid to reside in this facility with the above documented findings. Resident C#3 stated, "No, I'm not afraid but he does this to make me mad. I'm afraid one day he will do that and I will be up in my wheelchair and go and I just go and speak to him personally about this. I have told the admissions coordinator (resident stated her name to the surveyors) and I have spoken to the administrator, but not the one that is here now. I also called the police and they came here to talk to me about this incidence of pizza ordered and delivered to facility while I was in the hospital and the group chats and texts that I had received from the other resident. The police told me that there was no harm done and if I wanted to press charges, I would have to be taken down to the magistrate's office. I can't walk there and I have not been able to do this. I just don't want to get so mad that I go out in the hallway and hurt him." At 1:30 pm, Surveyor #1 and #2 went and interviewed the admissions coordinator. Surveyor #2 asked if she had been made aware of the above documented findings that Resident C#3 has had with his clothes missing and the use of his debit card that he did not give permission to do. The admissions coordinator stated, "Yes I am aware of this situation. And since we haven't had a social worker here since February (February 2019) I have been helping him to sort through all of this. He told me that his shirts and pants had be taken out of the room while he was in the hospital. He also showed me the group chats and texts he received from the other resident. I don't remember the exact dates but after that, if I did call the Ombudsman and the police. Both came and spoke to _____ (name of Resident	F 610	Effective 9/18/19 the Director of Nursing will report the findings of audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Dates when corrective action will be completed: October 4th, 2019 Title of the person responsible for implementing the acceptable plan of correction: MDS Coordinator	

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C#3). They told him the same thing about going to the magistrate's office to file a charge against this other resident." Surveyor #2 asked if she had documented everything that had been done for Resident C#3 concerning the above documented findings. The admissions coordinator stated, "I don't remember. If I did, you won't be able to see it because my screen looks a lot different from yours."

On 8/14 and 8/16/19, Surveyor #2 reviewed the clinical record. The care plan was also reviewed. There was no documentation of interventions that had been put into place after the above described incident had occurred. In addition, there was no documentation of an assessment performed on Resident C#3 concerning this matter. However, the was documentation in the nurses' notes dated and timed for 7/7/19 at 9:32 am which read, " ...Resident called this nurse to his room to report the following ...Resident states that he believes former roommate has stolen the following items, an LG phone with cell phone pictures of family. _____ (name of resident) states that former room mate made comments about holding possession of this phone in his safe claiming that it is his cell phone. He is also alleging that the former room mate has used his debit card without his authorization to delivery and pick up food on several different occasions. He also alleges that the former roommate has stolen his clothes by either having staff place them in his closet or having them removed from the facility. _____ (name of Resident) also purchased a surround sound from this roommate and states that he is holding the cables and will not allow him to have them thus resident is unable to use this device. _____ (name of Resident) has expressed to this nurse at this time that he would like the

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authorities contacted so that he may press charges ..."

On 7/7/19 at 15:41 (3:41 pm), Surveyor #2 noted the following entries in Resident C#3's clinical record. It read in part, " ...Resident has called this nurse to his room to report that he is receiving threatening messages from previous roommate. Resident then pulled out his phone and stated that he had deleted the threatening but that they had been there. A short while later resident called this nurse to the room to report that he was being contacted by _____ (name of friend) a friend of previous roommate, asking why he had said the things he said. Resident also reported that he was receiving numerous hang up phone calls from a restricted number. He stated he does not fear for his safety where previous previous roommate is concerned. However, he does fear for his safety because of friends/family ..."

At 17:05 (5:05 pm) the surveyor noted the following documentation in the nurses notes that read in part " ...Roanoke city police returned to the facility to address issues of resident fearing for his safety, during the time of waiting for law enforcement to arrive resident spoke with this nurse and DON (director of nursing), stating that he received a phone call from a female voice saying that, "you are going to get what coming to you., you are a piece of _____ (profanity used by the caller) and we are going to get you." Roanoke city police entered facility and spoke with this nurse and DON stating that there was nothing that he could legally do as there was no proof as to where or who was placing the phone calls. Officer stated that _____ (name of resident) could try to obtain a protective order,

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however it would expire after 72 hours and there was nothing that could be done after that.

On 8/14/19 at 2:30 pm, the survey team met with the administrator and DON (director of nursing) and asked if the facility had made any additional assessments following this incident, were interventions put in place as to not have this reoccurring and was staff educated on how to keep these residents separated. The administrator stated, "I don't know but I will get you a copy of the resident's care plan for you to review. The surveyor received a copy of the resident's care plan and the surveyor stated to the administrator that there was no interventions put into place after this incident. The administrator stated, "From what you are telling me today, I feel you have all the information that I have. The DON and myself haven't been here but 2 weeks prior to this survey and I can't speak to what was done or if staff was educated to keep these 2 residents from each other." The surveyor requested the phone number of LPN (licensed practical nurse) #1 so that the surveyor could speak to her concerning this matter since she was on duty when this occurred. The administrator gave the phone number to the surveyor as requested. At approximately 3:10 pm, the surveyor attempted to reach LPN #1 by phone but there was no answer.

On 8/15/19 at 9 am, the survey team spoke to the Ombudsman in the conference room. The Ombudsman stated that she had been working with this resident about his concerns. She stated, "I don't have any clear cut answers because the police told me the same thing when I called them about this incident. The answer I got was to have the resident be able to go in person but that is a

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F 610	Continued From page 22 challenge because someone from the facility would have to go with him and he would have to be taken there by an ambulance since he is unable to walk/stand." No further information was provided to the surveyor prior to the exit conference on 8/20/19.	F 610		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that residents receive treatment and care in accordance with the resident's preferences and/or by following physician's orders for 6 of 10 residents in the survey sample (Resident #C1, #C2, #C3, #C6, #C10 and #C8). The findings included: 1. Resident #C1 was admitted to the facility on 10/16/18 with the following diagnoses of, but not limited to neurogenic bladder, quadriplegia, depression and respiratory failure. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/22/19, coded	F 684	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Physician was notified of medications given an hour or later after the medications had been scheduled on the MAR for resident #C1 on 8/15/19 by director of nursing with no new orders given. Physician was notified of medications given an hour or later after the	10/4/19

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F 684	Continued From page 23 the resident as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing. Resident #C1 was also coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. On 8/14/19 at 2:30 pm, the resident asked to speak to the surveyors that were in the building. The facility staff pushed Resident #C1's chair into the conference room. Surveyor #1 and #2 attended also. The resident stated, "I don't get my medicine on time. It's never being given to me when it is supposed to be given. Surveyor #2 stated to the resident that this concern would be reviewed and see why the medications are not given on time. At 3 pm, Surveyor #1 requested copies of the time analysis for Resident #C1 for the dates of 7/1/19 through 8/15/19 concerning administration of medications. The administrator and DON (director of nursing) stated they would obtain copies of this report and give to the surveyor. At 4:30 pm, the administrator brought the requested copies to the surveyor. In the time analysis report of the resident's MAR (medication administration record) the dates of 7/1/19 through 8/15/19, the surveyor noted the following documentation: a) " ...Glycopyrrolate 1 mg (milligram) Give 2 tablet by mouth three times a day for secretions. The medication was schedule for 09:00, 1400 (2 pm) and 2100 (9 pm) ..." The facility staff documented that this medication had been given to Resident #C1 1-4 hours after the time that this medication was scheduled to be given.	F 684	medications had been scheduled on the MAR for resident #C2 on 8/15/19 by director of nursing with no new orders given. Physician was notified of omissions of medication as well as medications given an hour or later after the medication was scheduled to be given for resident #C3 on 8/15/19 by director of nursing with no new orders given. Physician was notified that resident #C6 had missed six doses of IV antibiotic on 8/19/19 by director of nursing with no new orders given. Physician was notified of omissions of medication as well as medications given an hour or later after the medication was scheduled to be given for resident #C10 on 8/19/19 by director of nursing with no new orders given. Physician was notified of omissions of medication as well as medications given an hour or later after the medication was scheduled to be given for resident #C8 on 8/15/19 by director of nursing with no new orders given. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of the MAR was conducted by the Director of Nursing, and will be completed by 9/19/19, to identify any missed medications as well as a time analysis to identify concerns and or needed follow up.	

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F 684	Continued From page 24 b) Trazodone 100 mg Give 1 tablet by mouth one time a day for depression. Take a bedtime. The medication was scheduled to be given at 2100 (9 pm). On 7/1/19, it was given at 02:03 (2:03 am), 7/5/19 it was given at 2244 (10:44 pm), 7/6/19 it was given at 2226 (10:26 pm), 7/7/19 it was given at 0410 (4:10 am) on 7/8/19, 7/9/19 was given at 0257 (2:57 am) on 7/10/19, 7/11/19 it was given at 0120 (1:20 am) on 7/12/19, 7/12/19 was given at 2223 (10:23 pm), 7/14/19 was given at 2236 (10:36 pm), 7/19/19 was given at 2311 (11:11 pm), 7/20/19 was given at 0122 (1:22 am) on 7/21/19, 7/22/19 was given at 2317 (11:17 pm), 7/23/19 was given at 2320 (11:20 pm), 7/24/19 was given at 0037 (12:37 am) on 7/25/19, 7/25/19 was given at 0022 (12:32 am), 7/26/19 was given at 2231 (10:31 pm), 7/21/19 was given at 0030 (12:30 am) on 7/22/19, 7/27/19 was given at 2253 (10:53 pm), 7/28/19 was given at 2224 (10:24 pm), 8/3/19 was given at 2305 (11:05 pm), 8/5/19 was given at 2353 (11:53 pm), 8/6/19 was given at 0106 (1:06 am) on 8/7/19, 8/10/19 was given at 2350 (11:50 pm) and 8/14/19 was given at 2235 (11:35 pm). The surveyor reviewed the nurses' notes for the above documented dates and times. There was no documentation to state why the resident was receiving medications other than how they had been scheduled. On 8/16/19 at 10 am, the DON (director of nursing) and the administrator were notified of the above documented findings. The DON stated, "I was not aware of this going on with this resident until you requested copies of this report. I would expect the nurses to notify the physician of why the medications were not being administrated as	F 684	All identified concerns were reported to the physician and addressed under their advisement. An audit of current residents with new orders and narcotics was conducted on 09/18/2019 by the Director of Nursing with follow up completed as needed. Monitoring process and systemic changes to ensure plan of correction is effective: The licensed nursing staff were educated on 8/27/19 by Administrator and DON regarding notification of physician when a medication is not available, medications given an hour or later after the medication was scheduled to be given, timely IV antibiotics administration, and the procedure for ordering medications and ensuring availability. Weekly audits will be conducted by Director of Nursing to review current resident□s medication administration times as well as medication availability for new orders for 4 weeks then monthly for 2 months. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: Effective 9/18/19 the Director of Nursing will report the findings of audits to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance.	

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F 684	Continued From page 25 ordered by the physician and then scheduled by the pharmacy. Either give the medication an hour before or an hour after the medication was scheduled." No further information was provided to the surveyor prior to the exit conference on 8/21/19. 2. The facility staff failed to follow physician orders concerning the administration of Baclofen and Morphine for Resident #C2. Resident #C2 was admitted to the facility on 3/27/17 with the following diagnoses of, but not limited to high blood pressure, pneumonia, diabetes, stroke, quadriplegia, depression and respiratory failure. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) 6/5/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #C2 was also coded as being totally dependent on 1-2 staff members for dressing, personal hygiene and bathing. On 8/14/19 at 1 pm, Resident #C2 asked to speak to the surveyors that were in the building. The resident was able to come to the conference room using his motorized wheelchair. Resident #C2 stated to the survey team that he never got his medicine on time like he was supposed to. The survey team verbalized to the resident that the medications would be reviewed. The resident verbalized understanding. On 8/20/19 at 9 am, the surveyor reviewed the clinical record including the MAR (medication administration record) for 8/1/19 through 8/20/19. The surveyor requested copies of the time	F 684	Dates when corrective action will be completed: October 4th, 2019 Title of the person responsible for implementing the acceptable plan of correction: Director of Nursing or designee	

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analysis report for the above dates for this resident.

The administrator brought copies of the requested report to the surveyor. During this review, the following was noted in the documentation:

a) Baclofen 10 mg (milligram) Give 1.5 tablet by mouth three times a day. This medication was scheduled to be given to the resident at 12 am, 8 am and 4 pm. On 8/1/19, the medication was given at 14:13 (2:13 pm). On 8/3/19, it was given at 14:14 (2:14 pm), 8/4/19 was given at 15:33 (3:33 pm), 8/5/19 was given at 12:44 (12:44 pm), 8/6/19 was given at 18:35 (6:35 pm), 8/9/19 was given at 09:25 (9:25 am), 8/10/19 was given at 09:57 (9:57 am), 8/11/19 was given at 10:56 (10:56 am), 8/13/19 was given at 11:15 (11:15 am), 8/16/19 was given at 12:24 (12:24 pm) and8/18/19 was given at 09:58 (9:58 am).

b) Morphine 0.125 ml (milliliter) by mouth four times a day. On 8/1/19, it was scheduled to be given at 12:00 but was documented as being given at 14:13 (2:13 pm). 8/3/19 dose was scheduled to be given at 18:00 (6 pm) but was documented as being given on 8/4/19 at 07:52 (7:52 am). 8/4/19 was scheduled to be given at 12:00 but it was documented as being given at 15:53 (3:53 pm). 8/6/19 was scheduled to be given at 12:00 but it was documented as being given at 14:12 (2:12 pm). 8/7/19 was scheduled for 12:00 but it was documented being given at 16:08 (4:08 pm). 8/8/19 was scheduled to be given at 12:00 but it was documented as being given at 15:45 (3:45 pm).

On 8/16/19 at 10 am, the DON (director of

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nursing) and the administrator were notified of the above documented findings. The DON stated, "I was not aware of this going on with this resident until you requested copies of this report. I would expect the nurses to give the medications as ordered by the physician and on the scheduled times that have been put in from pharmacy. Either an hour before that time or an hour after that time."

No further information was provided to the surveyor prior to the exit conference on 8/21/19.

3. The facility staff failed to follow physician's orders concerning the administration of Valium to Resident #C3.

Resident C#3 was readmitted to the facility 7/29/19 with the following diagnoses of, but not limited to anemia, orthostatic hypotension, neurogenic bladder, septicemia, anxiety disorder, manic depression and quadriplegia. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/2/19, the resident had a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident C#3 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing.

On 8/14/19, the resident asked to speak to a surveyor. At approximately 10 am, the surveyor went into the resident's room to speak to the resident. During this interview, the resident stated that the facility " ...ran out of my medicine at different times and I don't have it to take ..." The surveyor reviewed Resident #C3's MAR (medication administration records) and the nursing notes for July and August of 2019.

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During this review, it was noted that for the dates of 8/3, 8/4, 8/6 and 8/7 the resident was scheduled to have Diazepam 10 mg (milligram) by mouth at 9 am and 9 pm. On these dates, the nurses' documented a "9" for the 9 am dose. According to the chart code on the MAR, "9" is for " ...Other/See Nurses Notes ..." When the surveyor reviewed the nursing notes for this resident, the following was noted:

o "8/3/19 at 14:38 (2:38 pm)" the following documentation: " ...Awaiting pharmacy orders for medication RP (resident responsible person) and MD (medical doctor) advised. Will give upon arrival ..."
o "8/4/19 10:59 (10:59 am) " ...Awaiting further instructions for meds per pharmacy and MD will give upon arrival ..."
o 8 /6 /19 04:21 (4:21 am), " ...This dose was not given. Authorization code not given by pharmacist. Will notify MD that dose was not given ..."
o 8 /6 /19 11:06 (11:06 am), " ...pharmacy is yet to supply. Prn (as needed) pain pills given ..."
o 8/7/19 10:04 (10:04 am) " ...Per pharmacy meds will be here today this nurse will give upon arrival ..."

The surveyor notified the administrator and DON (director of nursing) of the above documented findings on 8/16/19 at 10 am. The DON stated, "I don't know why the nurses would have it to give at one time and then not have it for another. This may have been when the pharmacy was being switched to the new company." The surveyor requested and received the facility's "STAT BOX" contents. On this list, Valium was not listed as being available in the STAT BOX to give to the resident.

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No further information was provided to the surveyor prior to the exit conference on 8/21/19.
4. The facility staff failed to ensure that Resident # C6 had received the complete course of antibiotics as ordered by the physician to treat a sputum infection.

Resident # C6 was a 65-year-old-male who was originally admitted to the facility on 1/16/19, with a readmission date of 7/26/19. Diagnoses included but were not limited to. BPH (benign prostatic hyperplasia), anxiety, heart failure, and hypertension.

The clinical record for Resident # C6 was reviewed on 8/19/19 at 2:45 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/30/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # C6 had a BIMS score (brief interview for mental status) of 14 out of 15, which indicated that Resident # C6 was cognitively intact. Section H of the MDS assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # C6 had an indwelling catheter.

The current plan of care for Resident # C6 was reviewed and revised on 4/10/19. The facility staff documented a focus area for Resident # C6 as, "Resident # C6 requires ventilator support." Interventions included but were not limited to, "Administer medications as ordered."

On 8/20/19 at 11:00 am, the surveyor reviewed the current orders for Resident # C6. The surveyor observed that Resident # C6 had an

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order that had been initiated by the physician on 7/28/19 for "Cefepime HCl Solution 2 gm (grams)/100ml (milliliters) Use 2 gram intravenously every 8 hours for sputum infection until 8/3/19." The surveyor reviewed the July and August 2019 medication administration records for Resident # C6 and observed documentation that Resident # C6 did not receive Cefepime as ordered by the physician on the following dates and times:
7/28/19 at 8:00 am
7/30/19 at 8:00 am
7/30/19 at 4:00 pm
7/30/19 at 12:00 midnight
7/31/19 at 12:00 midnight
8/2/19 at 4:00pm

The surveyor reviewed the entire clinical record for Resident # C6 and did not locate any follow up with the physician to notify that Resident # C6 had missed six doses of IV Cefepime that had been ordered to treat a sputum infection for Resident # C6. The surveyor also did not observe any follow up labs to determine if Resident # C6's sputum infection had resolved since the entire course of antibiotics had not been delivered per physician's orders.

The facility policy on "Change in a Resident's Condition or Status" contained documentation that included but was not limited to, ..."The nurse will notify the resident's attending physician or physician on call when there has been a (an): e. need to alter the resident's medical treatment significantly." ...

On 8/20/19 at 4:06 pm, the administrator and director of nursing were made aware of the findings as stated above and provided the

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opportunity to submit additional information to the survey team.

On 8/21/19 at 9:54 am, the director of nursing informed the surveyor that no documentation of physician notification that Resident # C6 had missed six doses of IV Cefepime for the treatment of a sputum infection.

No further information regarding this issue was presented to the survey team prior to the exit conference on 8/21/19.

5. Facility staff failed to provide Resident #C-10's Clonazepam after a revisit. The resident returned to the facility on Friday 8-16-19. She did not receive her physician ordered Clonazepam until the evening of 8/19/19. Resident #C-10's clinical record was reviewed on 8/20/19.

Resident #C-10 was readmitted to the facility on 8-16-19 following a hospitalization. Her diagnoses included neurogenic bladder, anxiety disorder, depression, manic depression, respiratory failure, chronic pain due to trauma and paraplegia.

The latest MDS (minimum data set) dated 5/23/19, and prior to the resident's discharge and readmission, documented the resident's cognitive status was unimpaired. The resident did require facility staff assistance for all the ADLs (activities of daily) living due paralysis following a cervical injury.

Resident #C-10's CCP (comprehensive care plan) reviewed and revised on 5/9/19 documented the resident still required the use of an anti-anxiety medication. The interventions included "Administer medications per MD (medical doctor) order/ Monitor for side

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effects/report to MD....."

Resident #C-10 readmission physician's orders, dated on 8/16/19, included the following verbal order, "clonazepam tablet 0.5 MG. Give 0.5 mg by mouth three times a day related to ANXIETY DISORDER, UNSPECIFIED...."

Resident #C-10's MAR (medication administration record was reviewed for August 2019. It documented the resident received clonazepam 0.5 mg three times daily between 8/1/19 and 8/6/19. On 8/7/19 the resident received only one dose at 6:00 AM.

The MAR contained no additional administrations of the 0.5 MG clonazepam until 8/20/19 at 9:00 AM. The MAR contained a one time administration of clonazepam 1 MG for "shortness of breath" at 11:59 PM.

The hospital progress notes were reviewed. The resident was admitted on 8/6/19 at 7:12 PM. She was discharged back to the facility on on 8/16/19. During her stay at the hospital the resident was documented as receiving clonazepam 0.5 MG three times daily as part of her treatment.

The nursing progress notes included the following entries just prior to the resident's hospitalization and since the resident's readmission:
8/7/19 @ 04:24 - "pt. sent to hospital for IV placement at the start of my shift. once at the hospital the pt. was admitted. Diagnosis unclear at this time....."
8/16/19 @ 15:22 - "Received resident back from hospital...."
8/16/19 @19:05 - "....Resident medications faxed to RX (pharmacy) and confirmed by (name of

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nurse practitioner) NP I ...."
8/18/19 @ 23:02 - ...."clonazepam tablet 0.5 MG. Give 0.5 mg three times a day related to anxiety disorder... awaiting arrival from pharmacy MD/Rsd aware, unable to pull from stat box due to needing a new script. Awaiting pharmacy to receive new script...."
8/19/19 @ 17:00 -- "RSD (resident) was up to chair, awake alert and talking. She had been experiencing anxiety most of the day, nurse aware...." This note was signed by the respiratory therapist.
8/19/19 @ 22:19 -- "......clonazepam 0.5 MG......hold due to 1 MG one time order given this shift per physician's order....."

The readmission screening, dated 8/16/19, was reviewed. The readmission screening contained a set of VS (vital signs) which were documented on 8/6/19--prior to the discharge. The clinical record contained no documentation of any VS that were obtained since the resident's readmission.

On 8/20/19 at 10:30 AM the surveyor was called to Resident #C-10's room for an interview. The resident told the surveyor that she had been at the hospital for treatment of an infection the week prior. The resident said she returned to the facility on 8/16/19 at around 2:00 PM. She said from the time of her re-entry, until late on the evening of 8/19/19, she had not received her clonazepam as ordered.

Resident #C-10 stated, "I got back from the hospital and they were out of my Klonopin (clonazepam). I didn't get any until Monday night (8/19/19) and they had to get it from the STAT box. I was going into withdrawal. I've never had that happen before....My blood pressure was up

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to 180/44 and I cried for two days and got short of breath because they didn't give me my Klonopin....."

The resident said she had informed both the DON and the administrator of her complaint on Monday morning (8/19/19). The resident stated, "I told them both what was going on and they didn't do anything either! I cried and no one would even listen...."

The resident told the surveyor the name of the only person in the facility who would listen and stated, "It's not even his job to get medications--but he was the one that finally helped me get my Klonopin".

The staff member was named and later confirmed to be the MDS coordinator. He acknowledged he became aware of the situation on 8/19/19 and was active involved in facilitating the procurement of the resident's medication for her after she spoke to him. He declined to detail his involvement.

On 8/20/19 at 10:35 AM, NPI entered the resident's room for an examination. NPI told the surveyor the nursing staff had not contacted the provider about the unavailability of the clonazepam until 8/1/9/19. NPI said the clonazepam required a hard script copy which he could fax from his office to the pharmacy to facilitate the procurement of the medication.

NPI stated, "The nursing staff should have gotten it for her. They should have contacted the provider (doctor) on call and informed him of the need for the hard script so the pharmacy could fill the prescription. We can fax a hard copy to the

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pharmacy".

NPI said the not having the clonazepam could result in increased anxiety and an elevated blood pressure. The resident then informed NPI about her anxiety symptoms, tearfulness and shortness of breath since 8/16/19.

On 8/20/19 at 4:05 PM the administrator and DON were informed of this issue. The administrator said she was with the DON in her room when the resident complained about not receiving her Klonopin. The DON said she never heard the resident complain about not getting her medications.

The DON said she had filled out a complaint/grievance form for the resident on 8/19/19. The complain form was reviewed and contained the following, in part, "......Received meds late because the nurse was slow....." There was no mention of the resident not receiving her clonazepam sine her readmission. The DON failed follow up with the nursing staff after receiving the complaint on Monday to determine/investigate the issue and failed to contact the doctor or pharmacy about the resident not receiving her Klonopin.

The DON provided the surveyor with a copy of the facility's medication policy at 4:10 PM. She stated, "It doesn't say what to do about obtaining medications on admission."

No additional information was provided prior to the survey team exit on 8/21/19.
6. For Resisdent C8, faciliy staff failed to administer the intravenous antibiotic penicillin G per physician orders.

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Resident #C8 was readmitted to the facility on 8/19/19. Diagnoses included, but were not limited to, acute and subacute infective endocarditis, acute respiratory failure with hypoxia, need for assistance with personal care, acquired absence of right leg above knee, type 2 diabetes mellitus, intellectual disabilities, atherosclerotic heart disease, heart failure, venous insufficiency, severe sepsis with septic shock, essential hypertension, and acquired absence of other left toes. On the quarterly minimum data set assessment with assessment reference date 8/13/19, the resident was assessed as having long and short term memory deficits and moderately impaired ability for daily decision making. The resident was assessed as without signs of delirium or psychosis, and having exhibited wandering and rejection of care 1-3 days during the week prior to assessment.

The resident was admitted to the hospital on 8/13/19 with a temperature 102.8 Fahrenheit. Hospital staff reported to the department of social services that the resident's condition caused staff to suspect the resident's physical hygiene and wound care needs had been neglected. The report indicated the resident had dried feces on hands, abdomen and in pants. A dressing on the left leg was stuck to the resident's wound and difficult to remove. The resident was readmitted to the facility on 8/19/19. The surveyor asked for copies of the hospital discharge paperwork and orders, but did not receive them.

During clinical record review on 8/20/19, the surveyor noted that an order had been entered in the electronic clinical record for Penicillin G pot in dextrose solution 60000unit /ml (milliliter)use 1

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application intravenously every 4 hours for infection for 189 administrations start date 8/20/19. The medication administration record (MAR) was marked 9 (other/see nurse notes) on 8/20 at midnight and 4 AM on 8/20/19. The nurse's notes documented "Medication not available in facility. Pharmacy called and will send out." on 8/20 at 8 AM, the MAR was marked 5 (hold/ see nurse's notes). There was no nurse's note at 8 AM. A note at 10:53 AM documented "pharmacy confirmed delivery". The surveyor asked the resident's nurse, Unit2 LPN about the two entries. Unit2 LPN stated that the note meant that the nurse called the pharmacy and they pharmacy would send the medication. The nurse stated the 8 AM note meant the same thing. At 12:50 PM on 8/20, the surveyor asked the acting director of nursing about the procedure to obtain time sensitive medications for administration. The acting director of nursing stated that the medication had already arrived. On 8/20/19 at 2:30 PM, the surveyor asked if there was a back up pharmacy that could supply the medication. The acting director of nursing and Unit2 LPN stated the back up pharmacy did not carry the medication. An order to hold the medication until its arrival was entered in the electronic record under the medical director's name. Scheduled doses through noon dose on 8/21 were crossed out in the electronic MAR. The surveyor asked to discuss the order with the medical director. The acting director of nursing stated that a nurse practitioner had given the order, but orders can only be entered in the system under the medical director's name. The resident received the first dose of intravenous penicillin G on 8/20/19 at 8 PM.

Surveyors informed the administrator and acting

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F 684	Continued From page 38 director of nursing about concerns with medication availability during a summary meeting on 8/20/29.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, clinical record review, and facility document review, it was determined that the facility staff failed to provide services necessary to treat pressure ulcers for three (3) of ten (10) sampled residents (Resident #C4, Resident #C6, and Resident #C7). The findings included: 1. Facility staff members failed to provide Resident #C7 wound care, as ordered, to address a pressure ulcer. Resident #C7 was admitted on 5/29/19. Resident #C7's diagnoses included, but were not limited to:	F 686	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Physician was notified of treatments not being completed #C7 on 8/15/19 by director of nursing with no new orders given. No negative outcome was noted. Physician was notified of treatments not being completed #C4 on 8/15/19 by director of nursing with no new orders given. No negative outcome was noted. Physician was notified of treatments not being completed #C6 on 8/15/19 by director of nursing with no new orders given. No negative outcome was noted.	10/4/19

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F 686	Continued From page 39 respiratory failure, sequelae of Guillain-Barre Syndrome, dysphagia, and pressure ulcer. Resident #C7's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/5/19 assessed the resident with a BIMS (brief interview for mental status) of 12 out of 15; this assessment also documented the resident as having pressure ulcers that were present on admission/entry. On 8/16/19 at 11:00 a.m., the surveyor observed care provided to Resident #C7; this care included wound care to the resident's sacral pressure ulcer by licensed practical nurse (LPN) #12. When Resident #C7's adult diaper was removed it was noted that the sacral pressure ulcer did not have a dressing in place. LPN #12 reported the dressing could have come off, and not been reported to nursing staff, the last time the patient was cleaned. Review of Resident #C7's wound care documentation for August 2019 revealed that wound care was not documented as being performed on 8/9/19, 8/14/19, and 8/17/19. Resident #C7's wound care documentation for 8/19/19 had the number "9" documented instead of a 'check mark' (a 'check mark' would have indicated wound care had been provided). The facility's Director of Nursing (DON) was asked what the "9" meant. On 8/20/19 at 12:45 p.m., the DON reported the "9" documented for the 8/19/19 wound care meant to see the nurses note; the DON reported when reviewing the nurse's note that the note doesn't document if the wound care was provided. (The DON stated that nursing note related to the "9" documentation only repeated the wound care order.)	F 686	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of all residents with pressure injury was conducted on 9/19/2019 by the Director of Nursing to ensure orders were in place. A skin sweep will be conducted by 09/27/2019 by the Director of Nursing and Staff Development Coordinator and any identified concerns will reported to the physician, a treatment plan put into place, and the care plan updated. Monitoring process and systemic changes to ensure plan of correction is effective: The licensed nursing staff were educated on 08/27/2019 by Administrator and DON regarding policy and expectation of treatment services. Weekly visual audits will be conducted by Director of Nursing on a total of 5 residents to review for compliance of treatment services for 4 weeks then monthly for 2 months, to ensure wound care is delivered per physician orders. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: Effective 9/18/19 the Director of Nursing will report the findings of audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this	

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F 686	Continued From page 40 The facility's administrator provided the survey team with a facility document titled "Pressure Ulcers/Skin Breakdown - Clinical Protocol" (revised March 2014). This document included the following information under the heading of "Treatment/Management": "The physician will authorize pertinent orders related to wound treatment, including wound cleaning and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents if indicated for type of skin alteration." On 8/20/19 at 2:45 p.m., the facility DON provided the survey with a copy of Resident #C7's current wound care order for his/her sacral wound. This order was dated 6/17/19 at 2:46 p.m. This order stated the sacral wound care should be provided every day shift until resolved; this order stated the sacral wound should be cleaned with normal saline daily and have calcium alginate and border gauze applied daily. On 8/20/19 at 4:00 p.m., during a survey team meeting with the facility's Administrator and Director of Nursing, the failure of facility staff to consistently provide Resident C#7 with the provider ordered wound care was discussed. 2. Resident #C4 had been transferred to a local hospital just prior to the survey team entering the facility on 8/13/19. Resident #C4 did not return to the facility prior to the conclusion of the survey. The resident had multiple hospital visits/stays in the months preceding this survey. The following were dates of two (2) of Resident #C4's recent hospital stays/visits: 6/10/19 - 6/17/19 and 7/10/19 - 7/18/19. The resident also had a hospital visit on 6/19/19 which did not result in a	F 686	plan to ensure the facility remains in compliance. Include dates when corrective action will be completed: October 4th, 2019 Title of person responsible for implementing the acceptable plan of correction: Director of Nursing or designee	

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hospitalization.

Resident #C4 was admitted to the facility on 10/18/2018. Resident #C4's diagnoses included, but were not limited to: dependence on ventilator, quadriplegia, sacral osteomyelitis, tracheostomy, diabetes, and stage four breast cancer with metastasis to liver and lumbar spine.

Resident #C4's significant change minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/21/2019, indicated the resident was unable to complete the interview to obtain a Brief Interview for Mental Status (BIMS) score. This assessment also indicated the resident had one or more unhealed pressure ulcers/injuries.

Resident #C4's clinical documentation revealed provider orders to treat the resident's current wounds. Resident #C4's treatment documentation revealed wound care being provided according to provider orders.

Concerns with Resident #C4's wound care was brought to the facility staff's attention in June 2019. During the review/investigation of these concerns it was discovered that a facility staff member had documented that two (2) dressing changes had been completed when in actuality the dressing changes had not been completed. (The staff member, who documented wound care was provided when it had not been, resigned prior to the facility staff having an opportunity to implement corrective actions for the individual staff member.)

During an interview on 8/19/19 at 3:10 p.m., the facility's current Administrator (who was not the

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facility's administrator at the time of incorrect wound care documentation) was asked if aforementioned issue had been addressed by the facility's Quality Assurance program. The Administrator reported minutes of the facility's June 2019 Quality Meeting was not found/not available; the administrator reported the only documents from the June 2019 meeting were the facility's CASPER reports, admission and discharge lists, and the sign-in sheet. The Administrator reported that the issues related to wound care was not discussed during the facility's July 2019 Quality Assurance Meeting. No evidence was found by or provided to the survey team to indicate the facility's Quality Assurance program had acted to determine: (a) the cause for/contributing factors for the inaccurate wound care documentation, (b) if other residents were impacted by similar issues, and (c) what, if any, corrective action/changes was required of facility staff or facility processes.

On 8/20/19 at 4:00 p.m., during a survey team meeting with the facility's Administrator and Director of Nursing, the failure of facility staff to consistently provide Resident C#4 with the provider ordered wound care was discussed.
3. The facility staff failed to complete daily dressing changes to left heel as ordered by the physician for Resident # C6.

Resident # C6 was a 65-year-old-male who was originally admitted to the facility on 1/16/19, with a readmission date of 7/26/19. Diagnoses included but were not limited to, BPH (benign prostatic hyperplasia), anxiety, heart failure, and hypertension.

The clinical record for Resident # C6 was

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reviewed on 8/19/19 at 2:45 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/30/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # C6 had a BIMS score (brief interview for mental status) of 14 out of 15, which indicated that Resident # C6 was cognitively intact. Section M of the MDS assesses skin conditions. In Section M0210, the facility staff documented that Resident # C6 had one or more unhealed pressure ulcers/injuries.

The current plan of care for Resident # C6 was reviewed and revised on 4/10/19. The facility staff documented a focus area for Resident # C6 as, "Resident # C6 has the potential for pressure ulcer development r/t (related to) immobility, vent dependence, tube feeding, unstageable wound to left heel." Interventions included but were not limited to, "Follow facility policies/protocols for the prevention/treatment of skin breakdown."

Resident # C6 had current orders that included but was not limited to, "Left heel clean w (with)/n (normal) saline and apply betadine gauze and roll gauze daily till resolved," which had been initiated by the physician on 7/29/19.

On 8/19/19 at 1:50 pm, the surveyor was in Resident # C6's room along with CNA # 1 (certified nursing assistant). Resident # C6 agreed to allow the surveyor to observe the dressing to his left heel. CNA # 1 removed sock from Resident # C6's left foot. The surveyor observed Resident # C6's left foot wrapped with Kerlix and observed a date of 8/16/19, 7-3 documented on the dressing. CNA # 1 verified

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that the dressing on Resident # C6's left heel was documented 8-16-19, 7-3.

On 8/20/19 at 8:47 am, the surveyor, administrator, and director of nursing entered Resident # C6's room to observe the dressing to Resident # C6's left heel. The director of nursing and surveyor observed Resident # C6's left heel dressing and observed that 8-16-19, 7-3 was documented on the dressing to Resident # C6's left heel.

The facility policy on "Pressure Ulcers/Skin Breakdown-Clinical Protocol" contained documentation that included but was not limited to, ..."Treatment/Management
1. The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings (occlusive absorptive, ect.) and application of topical agents if indicated for type of skin alteration." ...

On 8/20/19 at 4:06 pm, the administrator and director of nursing were made aware of the findings as stated above and provided the opportunity to submit additional information to the survey team.

On 8/21/19 at 10:31 am, the surveyor, the director of nursing, and administrator entered Resident # C6's room to observe Resident # C6's left heel. The surveyor observed the director of nursing remove the sock from Resident # C6's left foot and the surveyor, director of nursing, and administrator observed that there was no dressing in place on Resident #C6's left heel.

No further information regarding this issue was

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F 686	Continued From page 45 presented to the survey team prior to the exit conference on 8/21/19.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, it was determined the facility staff failed to provide appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion by implementing a restorative plan/program for one (1) of ten (10) residents (Resident #C7). The findings included: Facility staff members failed to provide/implement a restorative care plan/program for Resident #C7.	F 688	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #C7 was screened and evaluated by occupational therapy, and a treatment plan put into place on 8/20/19. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/27/19, the Director of Nurses and Staff Development Coordinator	10/4/19

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F 688	Continued From page 46 Resident #C7 was admitted on 5/29/19. Resident #C7's diagnoses included, but were not limited to: respiratory failure, sequelae of Guillain-Barre Syndrome, dysphagia, and pressure ulcer. Resident #C7's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/5/19 assessed the resident with a BIMS (brief interview for mental status) of 12 out of 15; this assessment also documented the resident as having total dependence on staff for bed mobility, transfers, eating, and personal hygiene. During an interview on 8/20/19 at 9:30 a.m., the facility's Director of Therapy reported Resident #C7 had been discharged from therapy to the facility's restorative program. The following information was found in Resident #C7's care plan: - The "Focus" dated for 7/19/19 was "(Resident's name omitted) will be participating in restorative nursing services". - The "Goal" dated for 7/19/19 was "Will continue to function at current level while participating in restorative nursing program during this review." - The "Interventions" dated for 7/19/19 included "NURSING REHAB/RESTORATIVE: AROM/PROM up/out/across shoulder, wrist, hands, elbows, several sets of 10." (AROM = active range of motion; PROM = passive range of motion) On 8/20/19 at 12:45 p.m., the facility's Director of Nursing (DON) provided the survey team a copy of a facility document titled "Restorative Nursing Services" (revised July 2017). The document included the following information under the	F 688	re-educated Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants that residents will receive restorative nursing care as needed to help promote optimal safety and independence. An audit was completed on all patients with orders for restorative care on 9/18/19 by the Director of Nursing. Therapy will rescreen all residents with current restorative orders by September 27th, 2019 to validate the appropriate program. The monitoring processes and systemic changes to ensure plan of correction is effective: The Director of Nursing or designee will review 5 residents weekly, including the weekend, with orders for restorative to ensure that it is implemented as ordered. This will occur weekly for 4 weeks, then monthly for 3 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 9/18/19 the Director of Nursing will report the findings of audits to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Include dates when corrective action will be completed: October 4th, 2019	

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F 688	Continued From page 47 heading of "Policy Statement": "Residents will receive restorative nursing care as needed to help promote optimal safety and independence." On 8/20/19 at 12:45 p.m., the facility's DON provided the surveyor with a copy of a clinical document, dated 7/15/19, for Resident #C7 titled "Functional Maintenance Program"; the DON stated this document was provided by therapy but was not implemented. This document indicated Resident #C7 was to receive active range of motion (AROM) and passive range of motion (PROM) to shoulders, wrist, hands, and elbows. This form included the following information: "These programs are designed to maintain patient's ability to walk, transfer, perform activities of daily living, prevent further contractures, preserve skin condition, and/or to maintain a patient's quality of life. **Programs are to be performed with or without the addition of therapy services.**" On 8/20/19 at 4:00 p.m., during a survey team meeting with the facility's Administrator and Director of Nursing, the failure of facility staff to implement Resident #C7's restorative program/plan was discussed.	F 688	The title of the person responsible for implementing the acceptable plan of correction: Director of Nursing or designee	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		10/4/19

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F 690	Continued From page 48 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to provide services necessary to prevent urinary tract infections for 1 of 6 Residents in the survey sample, Resident # C6. The findings included The facility staff failed to ensure that Resident # C6 had current orders for a Foley catheter and	F 690	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: A current order for a foley catheter was received for resident #C6 on 8/20/19, and the foley was positioned and anchored to ensure catheter tubing was appropriately positioned to prevent the backflow of urine in the bladder immediately.	

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F 690	Continued From page 49 failed to ensure that the Foley catheter tubing was appropriately positioned to prevent the backflow of urine into the bladder. Resident # C6 was a 65-year-old-male who was originally admitted to the facility on 1/16/19, with a readmission date of 7/26/19. Diagnoses included but were not limited to. BPH (benign prostatic hyperplasia), anxiety, heart failure, and hypertension. The clinical record for Resident # C6 was reviewed on 8/19/19 at 2:45 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/30/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # C6 had a BIMS score (brief interview for mental status) of 14 out of 15, which indicated that Resident # C6 was cognitively intact. Section H of the MDS assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # C6 had an indwelling catheter. The current plan of care for Resident # C6 was reviewed and revised on 4/10/19. The facility staff documented a focus area for Resident # C6 as, "Resident # C6 is at risk for UTI (urinary tract infection) due to Foley catheter diagnosis of BPH, uropathy." Interventions included but were not limited to, "If s/s (signs and symptoms) meet McGreer criteria notify MD (medical doctor)." On 8/19/19 at 3:42 pm, the surveyor reviewed the current orders for Resident # C6. The surveyor did not locate any current orders for a Foley catheter for Resident # C6. On 8/20/19 at 8:52 am, the surveyor along with	F 690	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 9/18/19, the director of nursing and staff development coordinator reviewed current residents with foley catheters to ensure orders were present. Director of nursing and staff development coordinator visually checked each foley catheter to ensure each was appropriately positioned to prevent the backflow of urine. The monitoring processes and systemic changes to ensure plan of correction is effective: The Director of nursing/Unit Coordinator/Supervisors will review new orders for foley catheters orders daily to ensure they are all entered into the electronic record. Positioning will be checked by IDT during room rounds. On 8/27/19, the Director of Nursing and Staff Development Coordinator re-educated the licensed nurses and certified nursing assistants on monitoring orders and placement of foley catheters. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 9/18/19 the Director of Nursing will report the findings of audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in	

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F 690	Continued From page 50 the administrator and the director of nursing was in Resident # C6's room. The surveyor and the director of nursing observed that the Foley catheter tubing for Resident # C6 was positioned over a bed bolster, which promoted the flow of urine back into the bladder. The surveyor asked the director of nursing if the Foley catheter tubing for Resident # C6 was properly positioned to prevent the flow of urine back into the bladder. The director of nursing stated, "No." On 8/20/19 at 9:20 am, the surveyor and the director of nursing reviewed the current orders for Resident # C6. The director of nursing agreed that Resident # C6 did not have current orders for a Foley catheter. The facility policy on "Catheter Care, Urinary" contained documentation that included but was not limited to, ..."Maintaining unobstructed urine flow 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder." ... On 8/20/19 at 4:06 pm, the administrator and director of nursing were made aware of the findings as stated above and provided the opportunity to submit additional information to the survey team. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/21/19.	F 690	compliance. Include dates when corrective action will be completed: October 4th, 2019 The title of the person responsible for implementing the acceptable plan of correction: Director of Nursing or designee	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		10/4/19

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F 755	Continued From page 51 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure that pharmaceutical services for the accurate administering of all drugs to meet the needs of each resident were available by providing physician ordered medications for	F 755	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Physician was notified of omission of medication for #C2, #C3, #C8, #C10 on	

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F 755	Continued From page 52 administration to 4 of 10 residents in the survey sample (Resident #C2 and #C3, #C8 and #C10). The findings included: 1. The facility staff failed to ensure physician ordered medications, Famotidine and Arginaid, were available for administration to Resident #C2. Resident #C2 was admitted to the facility on 3/27/17 with the following diagnoses of, but not limited to high blood pressure, pneumonia, diabetes, stroke, quadriplegia, depression and respiratory failure. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) 6/5/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #C2 was also coded as being totally dependent on 1-2 staff members for dressing, personal hygiene and bathing. During the clinical record review of the resident's MAR (medication administration record) and nurses' notes for July 2019, the surveyor noted the following documentation, which was dated and timed for: a) "7/23/19 23:18 (11:18 pm) ...Famotidine 10 mg (milligram) Give 1 tablet by mouth two times a day ...on order ...Arginaid 1 packet, mix with 8-10 oz. (ounces) of honey thick consistency BID two times a day for supplement on order ..." On 8/16/19 at 9 am, the surveyor notified the administrator and DON (director of nursing) of the above documented findings. The DON stated, "I don't know why this was not here for the staff to give to the resident. I wasn't here working at that	F 755	8/15/19 by director of nursing with no new orders given. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit was completed on all new medication orders to ensure availability and administration on 9/17/19 by Director of Nursing. Monitoring process and systemic changes to ensure plan of correction is effective: The licensed nursing staff were educated on 08/27/2019 by Administrator and DON regarding policy and expectation of medication availability as well administration. Weekly audits will be conducted by Director of Nursing on a total of 15 residents to ensure medications are avialable for 4 weeks then monthly for 2 months. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: Effective 9/18/19 the Director of Nursing will report the findings of audits to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Include dates when corrective action will be completed:	

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F 755	Continued From page 53	F 755	October 4th, 2019 The title of the person responsible for implementing the acceptable plan of correction: Director of Nursing or designee	

time."

No further information was provided to the surveyor prior to the exit conference on 8/21/19.

2. The facility staff failed to ensure physician ordered medication, Diazepam (Valium), was available for administration to Resident #C3.

Resident C#3 was readmitted to the facility 7/29/19 with the following diagnoses of, but not limited to anemia, orthostatic hypotension, neurogenic bladder, septicemia, anxiety disorder, manic depression and quadriplegia. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/2/19, the resident had a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident C#3 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing.

On 8/14/19, the resident asked to speak to a surveyor. At approximately 10 am, the surveyor went into the resident's room to speak to the resident. During this interview, the resident stated that the facility " ...ran out of my medicine at different times and I don't have it to take ..."

The surveyor reviewed Resident #C3's MAR (medication administration records) and the nursing notes for July and August of 2019. During this review, it was noted that for the dates of 8/3, 8/4, 8/6 and 8/7, the resident was scheduled to have Diazepam 10 mg (milligram) by mouth at 9 am and 9 pm. On these dates, the nurses' documented a "9" for the 9 am dose. According to the chart code on the MAR, "9" is for " ...Other/See Nurses Notes ..." When the

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surveyor reviewed the nursing notes for this resident, the following was noted:

" "8/3/19 at 14:38 (2:38 pm)" the following documentation: " ...Awaiting pharmacy orders for medication RP (resident responsible person) and MD (medical doctor) advised. Will give upon arrival ..."

" "8/4/19 10:59 (10:59 am) " ...Awaiting further instructions for meds per pharmacy and MD will give upon arrival ..."
" 8/6/19 04:21 (4:21 am) " ...This dose was not given. Authorization code not given by pharmacist. Will notify MD that dose was not given ..."
" 8/6/19 11:06 (11:06 am) " ...pharmacy is yet to supply. Prn (as needed) pain pills given ..."
" 8/7/19 10:04 (10:04 am) " ...Per pharmacy meds will be here today this nurse will give upon arrival ..."

The surveyor notified the administrator and DON (director of nursing) of the above documented findings on 8/16/19 at 10 am. The DON stated, "I don't know why the nurses would have it to give at one time and then not have it for another. This may have been when the pharmacy was being switched to the new company." The surveyor requested and received the facility's "STAT BOX" contents. On this list, Valium was not listed as being available in the STAT BOX to give to the resident.

No further information was provided to the surveyor prior to the exit conference on 8/21/19.
3. For Resident C8, facility staff failed to collaborate with the pharmacy to ensure an IV antibiotic penicillin G was available for

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administration.

Resident #C8 was readmitted to the facility on 8/19/19. Diagnoses included, but were not limited to, acute and subacute infective endocarditis, acute respiratory failure with hypoxia, need for assistance with personal care, acquired absence of right leg above knee, type 2 diabetes mellitus, intellectual disabilities, atherosclerotic heart disease, heart failure, venous insufficiency, severe sepsis with septic shock, essential hypertension, and acquired absence of other left toes. On the quarterly minimum data set assessment with assessment reference date 8/13/19, the resident was assessed as having long and short term memory deficits and moderately impaired ability for daily decision making. The resident was assessed as without signs of delirium or psychosis, and having exhibited wandering and rejection of care 1-3 days during the week prior to assessment.

The resident was admitted to the hospital on 8/13/19 with a temperature 102.8 Fahrenheit. Hospital staff reported to the department of social services that the resident's condition caused staff to suspect the resident's physical hygiene and wound care needs had been neglected. The report indicated the resident had dried feces on hands, abdomen and in pants. A dressing on the left leg was stuck to the resident's wound and difficult to remove. The resident was readmitted to the facility on 8/19/19. The surveyor asked for copies of the hospital discharge paperwork and orders, but did not receive them.

During clinical record review on 8/20/19, the surveyor noted that an order had been entered in the electronic clinical record for Penicillin G pot in

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dextrose solution 60000unit /ml (milliliter)use 1 application intravenously every 4 hours for infection for 189 administrations start date 8/20/19. The medication administration record (MAR) was marked 9 (other/see nurse notes) on 8/20 at midnight and 4 AM on 8/20/19. The nurse's notes documented "Medication not available in facility. Pharmacy called and will send out." on 8/20 at 8 AM, the MAR was marked 5 (hold/ see nurse's notes). There was no nurse's note at 8 AM. A note at 10:53 AM documented "pharmacy confirmed delivery". The surveyor asked the resident's nurse, Unit2 LPN about the two entries. Unit2 LPN stated that the note meant that the nurse called the pharmacy and they pharmacy would send the medication. The nurse stated the 8 AM note meant the same thing. At 12:50 PM on 8/20, the surveyor asked the acting director of nursing about the procedure to obtain time sensitive medications for administration. The acting director of nursing stated that the medication had already arrived.

On 8/20/19 at 2:30 PM, the surveyor asked if there was a back up pharmacy that could supply the medication. The acting director of nursing and Unit2 LPN stated the back up pharmacy did not carry the medication. An order to hold the medication until its arrival was entered in the electronic record under the medical director's name. Scheduled doses through noon dose on 8/21 were crossed out in the electronic MAR. The surveyor asked to discuss the order with the medical director. The acting director of nursing stated that a nurse practitioner had given the order, but orders can only be entered in the system under the medical director's name. The resident received the first dose of intravenous penicillin G on 8/20/19 at 8 PM.

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Surveyors informed the administrator and acting director of nursing about concerns with medication availability during a summary meeting on 8/20/29.
4. Facility staff failed to collaborate with the pharmacy to obtain a physician ordered medication (Klonopin) for Resident #C-10 following a readmission on 8/16/19. The resident did not begin receiving the Klonopin until the evening of 8/19/19. Resident #C-10's clinical record was reviewed on 8/20/19.

Resident #C-10 was readmitted to the facility on 8-16-19 following a hospitalization. Her diagnoses included neurogenic bladder, anxiety disorder, depression, manic depression, respiratory failure, chronic pain due to trauma and paraplegia.

The latest MDS (minimum data set) dated 5/23/19, and prior to the resident's discharge and readmission, documented the resident's cognitive status was unimpaired. The resident did require facility staff assistance for all the ADLs (activities of daily) living due paralysis following a cervical injury.

Resident #C-10's CCP (comprehensive care plan) reviewed and revised on 5/9/19 documented the resident still required the use of an anti-anxiety medication. The interventions included "Administer medications per MD (medical doctor) order/ Monitor for side effects/report to MD....."

Resident #C-10 readmission physician's orders, dated on 8/16/19, included the following verbal order, "clonazepam tablet 0.5 MG. Give 0.5 mg by mouth three times a day related to ANXIETY

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DISORDER, UNSPECIFIED...."

Resident #C-10's MAR (medication administration record was reviewed for August 2019. It documented the resident received clonazepam 0.5 mg three times daily between 8/1/19 and 8/6/19. On 8/7/19 the resident received only one dose at 6:00 AM.

The MAR contained no additional administrations of the 0.5 MG clonazepam until 8/20/19 at 9:00 AM. The MAR contained a one time administration of clonazepam 1 MG for "shortness of breath" at 11:59 PM.

The hospital progress notes were reviewed. The resident was admitted on 8/6/19 at 7:12 PM. She was discharged back to the facility on on 8/16/19. During her stay at the hospital the resident was documented as receiving clonazepam 0.5 MG three times daily as part of her treatment.

The nursing progress notes included the following entries just prior to the resident's hospitalization and since the resident's readmission:
8/7/19 @ 04:24 - "pt. sent to hospital for IV placement at the start of my shift. once at the hospital the pt. was admitted. Diagnosis unclear at this time....."
8/16/19 @ 15:22 - "Received resident back from hospital...."
8/16/19 @19:05 - "....Resident medications faxed to RX (pharmacy) and confirmed by (name of nurse practitioner) NP I ...."
8/18/19 @ 23:02 - ...."clonazepam tablet 0.5 MG. Give 0.5 mg three times a day related to anxiety disorder... awaiting arrival from pharmacy MD/Rsd aware, unable to pull from stat box due to needing a new script. Awaiting pharmacy to

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receive new script...."
8/19/19 @ 17:00 -- "RSD (resident) was up to chair, awake alert and talking. She had been experiencing anxiety most of the day, nurse aware...." This note was signed by the respiratory therapist.
8/19/19 @ 22:19 -- "......clonazepam 0.5 MG.....hold due to 1 MG one time order given this shift per physician's order....."

The readmission screening, dated 8/16/19, was reviewed. The readmission screening contained a set of VS (vital signs) which were documented on 8/6/19--prior to the discharge. The clinical record contained no documentation of any VS that were obtained since the resident's readmission.

On 8/20/19 at 10:30 AM the surveyor was called to Resident #C-10's room for an interview. The resident told the surveyor that she had been at the hospital for treatment of an infection the week prior. The resident said she returned to the facility on 8/16/19 at around 2:00 PM. She said from the time of her re-entry, until late on the evening of 8/19/19, she had not received her clonazepam as ordered.

Resident #C-10 stated, "I got back from the hospital and they were out of my Klonopin (clonazepam). I didn't get any until Monday night (8/19/19) and they had to get it from the STAT box. I was going into withdrawal. I've never had that happen before....My blood pressure was up to 180/44 and I cried for two days and got short of breath because they didn't give me my Klonopin....."

The resident said she had informed both the DON and the administrator of her complaint on

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Monday morning (8/19/19). The resident stated, "I told them both what was going on and they didn't do anything either! I cried and no one would even listen...."

The resident told the surveyor the name of the only person in the facility who would listen and stated, "It's not even his job to get medications--but he was the one that finally helped me get my Klonopin".

The staff member was named and later confirmed to be the MDS coordinator. He acknowledged he became aware of the situation on 8/19/19 and was active involved in facilitating the procurement of the resident's medication for her after she spoke to him. He declined to detail his involvement.

On 8/20/19 at 10:35 AM, NPI entered the resident's room for an examination. NPI told the surveyor the nursing staff had not contacted the provider about the unavailability of the clonazepam until 8/1/9/19. NPI said the clonazepam required a hard script copy which he could fax from his office to the pharmacy to facilitate the procurement of the medication.

NPI stated, "The nursing staff should have gotten it for her. They should have contacted the provider (doctor) on call and informed him of the need for the hard script so the pharmacy could fill the prescription. We can fax a hard copy to the pharmacy".

NPI said the not having the clonazepam could result in increased anxiety and an elevated blood pressure. The resident then informed NPI about her anxiety symptoms, tearfulness and shortness

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F 755	Continued From page 61 of breath since 8/16/19. On 8/20/19 at 4:05 PM the administrator and DON were informed of this issue.	F 755		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and the review of documents, it was determined the facility staff failed to ensure a QA (quality assurance) program, to meet the facility's needs, as evidenced by facility staff failing to develop a plan to address wound care issues. The findings included: The facility staff had identified issues with wound care as evident by a Facility Reported Incident (FRI) and subsequent investigation during June of 2019. No evidence of these wound care issues being addressed by the facility's staff was found by or provided to the survey team. Current issues related to wound care were identified during the survey process. (Please see Tag 686 for additional information including wound care observations.) Documentation of the facility's June 2019 review/investigation of Resident #C4's family member's wound care concerns revealed facility	F 867	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility staff member responsible for documenting dressing changes for #C4 that were not actually completed was terminated in June of 2019. On 8/27/19 ,resident #C4□s wounds were re-evaluated by the wound physician and care team. Medical record was updated by Director of Nursing to reflect any changes. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of all residents with pressure injury was conducted on 9/19/2019 by the Director of Nursing to ensure proper orders were in place. A skin sweep will be conducted by	10/4/19

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F 867	Continued From page 62 staff found issues with wound care treatment and documentation. It was discovered that a facility staff member had documented that two (2) dressing changes had been completed when in actuality the dressing changes had not been completed. The staff member, who documented wound care was provided when it had not been, resigned prior to the facility staff having an opportunity to implement corrective actions; the facility staff did report this individual to the state board of nursing. During an interview on 8/19/19 at 3:10 p.m., the facility's Administrator was asked if the issues reported in a facility reported incident (FRI), related to wound care, had been addressed by the facility's Quality Assurance program. The Administrator reported minutes of the facility's June 2019 Quality Meeting was not found/not available; the administrator reported the only documents from the June 2019 meeting were the facility's CASPER reports, admission and discharge lists, and the sign-in sheet. The Administrator reported that the issues related to wound care in the FRI was not discussed during the facility's July 2019 Quality Assurance Meeting. (The facility's Administrator interviewed was the current Administrator but not the facility's administrator at the time of the facility's June Quality meeting.) On 8/20/19 at 1:45 p.m., the facility's Administrator provided the survey team with a facility document titled "Quality Assurance and Performance Improvement (QAPI) Committee" (dated July 2016). This document included the following information under the heading "Goals of the Committee": "The primary goals of the QAPI Committee are to: 1. Establish, maintain and	F 867	09/27/2019 by the Director of Nursing and any identified concerns will reported to the physician and addressed accordingly. Residents that are treated for skin issues will be discussed weekly with the IDT to review the orders, treatment being delivered, and care plan updated to reflect changes. The monitoring processes and systemic changes to ensure plan of correction is effective: 1. On 9/17/19 the Administrator was re-educated on the Quality Assurance and Improvement Plan policy by the Regional Director of Operations. Resources for further education, and ongoing support provided. 2. On 9/18/19 all department heads were re-educated on the Quality Assurance and Improvement Plan policy by the Administrator. 3. On 9/18/19 the facility QAPI Committee held a meeting to review the purpose and function of the QAA committee and review on-going compliance issues. The Medical Director, Administrator, DON, MDS Coordinator, Maintenance Director, Supply Clerk, Dietary Manager, Activity Director, Medical Record Supervisor and Housekeeping Supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. Indicate how the facility plans to monitor its performance to make sure that	

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F 867	Continued From page 63 oversee facility systems and processes to support the delivery of quality of care and services; 2. Promote the consistent use of facility systems and processes during provision of care and services; 3. Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately..." This document included the following information under the heading "Committee Audit Process": "1. The QAPI Committee will scrutinize all department reports and summarize the findings in the committee minutes. 2. The QAPI Committee shall help various departments/ committees/ disciplines/ individuals develop and implement plans of correction and monitoring approaches. These plans and approaches should include specific time frames for implementation and follow-up ..." On 8/20/19 at 4:00 p.m., during a survey team meeting with the facility's Administrator and Director of Nursing, the failure of facility staff to ensure the aforemeniontedwound care issues were included in the facility's Quality Assurance Program was discussed. This is a complaint deficiency.	F 867	solutions are sustained: Facility will monitor identified issues weekly times 4 weeks and monthly times 2 months. The Director of Nursing will provide a monthly report to QAPI committee that will reflect a review of residents that require treatments for pressure injury that will include a review of the orders, treatment records, and care plan updates. Dates when corrective action will be completed: 10/4/19 Title of person responsible for implementing acceptable plan of correction: Administrator	